United States Department of Labor
Employees' Compensation Appeals Board

J.H., Appellant	)	
and	)	**Docket No. 09-165**
	)	**Issued: July 9, 2009**
DEPARTMENT OF THE TREASURY, INTERNAL REVENUE SERVICE, Philadelphia, PA, Employer	)	

Appearances:
Thomas R. Uliase, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
DAVID S. GERSON, Judge
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On October 22, 2008 appellant filed a timely appeal from January 2 and July 30, 2008 decisions of the Office of Workers' Compensation Programs, adjudicating his claim for a schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant has more than three percent permanent impairment of the left lower extremity for which he received a schedule award.

FACTUAL HISTORY

On April 20, 2006 appellant, then a 21-year-old tax examiner, sustained a traumatic injury to his back and both legs when he bent over to pick up a bundle of folders. The Office accepted his claim for aggravation of preexisting herniated discs at L4-5 and L5-S1. On October 23, 2007 appellant filed a claim for a schedule award.

In a May 11, 2007 report, Dr. Lawrence I. Barr, an osteopathic physician, stated that his associate, Dr. Marck L. Kahn, an orthopedic surgeon, saw appellant in January 2004 for a motor vehicle accident sustained on August 4, 2003 which resulted in an acute traumatic lumbosacral strain and sprain with post-traumatic disc herniations at L4-5 and L5-S1. On April 4, 2007 Dr. Kahn diagnosed a new condition, a bulging disc at L3-4 secondary to the April 20, 2006 employment injury. On May 11, 2007 Dr. Barr provided findings on physical examination which included tenderness in the left sacroiliac notch area, full range of motion, normal strength, reflexes +2/4 equal and reactive bilaterally and sensation grossly intact to light touch. In a supine position, appellant could not straighten out his legs due to back pain. Dr. Kahn diagnosed acute exacerbation of chronic lumbar strain and sprain with prior herniated discs at L4-5 and L5-S1 with a history of a bulging disc at L3-4.

In a report dated June 21, 2007, Dr. Nicholas Diamond, a specialist in pain management, reviewed appellant's medical history and provided findings on physical examination. Sitting root sign was positive to 50 degrees on the left. Straight leg raising was positive to 25 degrees on the left. Extensor hallucis longus was graded at 5/5 bilaterally. Sensory examination failed to reveal any perceived sensory deficit involving the right or left lower extremity. Deep tendon reflexes were +3 involving both lower extremities, patella and +1 involving the left lower extremity, Achilles. Manual muscle testing was graded at 4 to 4+ involving the left lower extremity, hip abductors and hip adductors. Dr. Diamond calculated 21 percent impairment of the left lower extremity. This was based on 16 percent for Grade 4 motor strength deficit of the left hip abductor superior gluteal nerve (62 percent maximum for the superior gluteal nerve multiplied by 25 percent for Grade 4 motor deficit equals 15.5 percent, rounded to 16 percent) based on Table 17-37 at page 552 and Table 16-11[1] at page 484 of the fifth edition of the of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*), 2 percent for Grade 4 motor deficit of the left hip abductor obturator nerve (7 percent maximum for the obturator nerve multiplied by 25 percent for Grade 4 motor deficit equals 1.75 percent, rounded to 2 percent), and 3 percent for pain-related impairment based on Figure 18-1 at page 574.

On November 20, 2007 Dr. Arnold T. Berman, an orthopedic surgeon and an Office medical adviser, reviewed Dr. Diamond's report and the fifth edition of the A.M.A., *Guides*. He noted that Dr. Barr found that appellant had left-sided complaints but sensation was intact and strength and reflexes were normal. Dr. Berman noted that Dr. Diamond's report calculated impairment for loss of strength for appellant's left hip abductors but other physicians did not verify this finding. He noted that the A.M.A., *Guides* provides at page 508, section 16.8a, that decreased strength cannot be rated in the presence of painful conditions that prevent effective application of maximal force in the region being evaluated. Dr. Berman stated that Dr. Diamond's calculation of impairment due to loss of strength could not be accepted. He calculated three percent impairment of appellant's left lower extremity based on Tables 15-15 (Determining Impairment Due to Sensory Loss) and 15-18 (Unilateral Spinal Nerve Root Impairment Affecting the Lower Extremity) at page 424 from Chapter 15 (The Spine). Dr. Berman multiplied 5 percent maximum impairment for sensory deficit of the L5 and S1

[1] Dr. Diamond cited Table 16-10 at page 482. However, Table 16-10 involves sensory deficit. Table 16-11 is used for determining impairment due to motor deficit.

nerve roots by 25 percent for Grade 4 sensory loss which equals 1.25 percent for each nerve root or 2.5 percent total impairment, rounded to 3 percent for the left lower extremity.[2]

By decision dated January 2, 2008, the Office granted appellant a schedule award based on three percent impairment of the left lower extremity for 60.48 days, or 8.64 weeks, from June 21 to August 20, 2007.[3]

Appellant requested an oral hearing before an Office hearing representative that was held on May 13, 2008. By decision dated July 30, 2008, the Office hearing representative affirmed the January 2, 2008 decision.[4]

LEGAL PRECEDENT

Section 8107 of the Federal Employees' Compensation Act[5] authorizes the payment of schedule awards for the loss or loss of use of specified members, organs or functions of the body. Such loss or loss of use is known as permanent impairment. The Office evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides*.[6]

The A.M.A., *Guides* provides for three separate methods for calculating the lower extremity permanent impairment of an individual: anatomic, functional and diagnosis based.[7] The anatomic method involves noting changes, including muscle atrophy, nerve impairment and vascular derangement, as found during physical examination.[8] The diagnosis-based method may be used to evaluate impairments caused by specific fractures and deformities, as well as ligamentous instability, bursitis and various surgical procedures, including joint replacements and meniscectomies.[9] The functional method is used for conditions when anatomic changes are

[2] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Award and Permanent Disability Claims*, Chapter 2.808.6(d) (October 2005) (these procedures contemplate that, after obtaining all necessary medical evidence, the file should be routed to an Office medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the medical adviser providing rationale for the percentage of impairment specified, especially when there is more than one evaluation of the impairment present).

[3] The Federal Employees' Compensation Act provides for 288 weeks of compensation for 100 percent loss or loss of use of the lower extremity. 5 U.S.C. § 8107(c)(2). Multiplying 288 weeks by 3 percent total for the left lower extremity equals 8.64 weeks of compensation.

[4] Subsequent to the July 30, 2008 Office decision, additional evidence was associated with the file. The Board's jurisdiction is limited to the evidence that was before the Office at the time it issued its final decision. *See* 20 C.F.R. § 501.2(c). The Board may not consider this evidence for the first time on appeal.

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404 (1999). Effective February 1, 2001, the Office began using the A.M.A., *Guides* (5th ed. 2001).

[7] A.M.A., *Guides* 525.

[8] *Id.*

[9] *Id.*

difficult to categorize, or when functional implications have been documented, and includes range of motion, gait derangement and muscle strength.[10] The evaluating physician must determine which method best describes the impairment of a specific individual based on patient history and physical examination.[11] When uncertain about which method to use, the evaluator should calculate the impairment using different alternatives and choose the method or combination of methods that gives the most clinically accurate impairment rating.[12] If more than one method can be used, the method that provides the higher impairment rating should be adopted.[13]

Section 8123(a) of the Act provides that "if there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary [of Labor] shall appoint a third physician who shall make an examination."[14] Where a case is referred to an impartial medical specialist for the purpose of resolving a conflict, the opinion of such specialist, if sufficiently well rationalized and based on a proper factual and medical background, must be given special weight.

ANALYSIS

Dr. Diamond provided findings on physical examination. He calculated 21 percent impairment of appellant's left lower extremity, including 16 percent for Grade 4 motor strength deficit of the left hip abductor superior gluteal nerve based on Table 17-37 at page 552 and Table 16-11 at page 484 of the fifth edition of the of the A.M.A., *Guides*, 2 percent for Grade 4 motor deficit of the left hip abductor obturator nerve and 3 percent for pain-related impairment based on Figure 18-1 at page 574.[15]

Dr. Berman stated that the A.M.A., *Guides* provides that decreased strength cannot be rated in the presence of painful conditions that prevent effective application of maximal force in the region being evaluated. Therefore, Dr. Diamond's calculation of 18 percent impairment due to loss of strength could not be accepted. The section of the A.M.A., *Guides* cited by Dr. Berman, section 16.8a, is applicable to the rating of impairment to the upper extremities. This was harmless error, however, as it appears that the cross-usage chart at Table 17-2 precludes combining impairment based on loss of muscle strength with impairment for peripheral nerve injuries of the lower extremities. Dr. Berman calculated three percent impairment of appellant's left lower extremity based on Tables 15-15 and 15-18 at page 424 from Chapter 15. He rated impairment for sensory loss affecting the lower extremity from the

[10] *Id.* at 525, Table 17-1.

[11] *Id.* at 548, 555.

[12] *Id.* at 526.

[13] *Id.* at 527, 555.

[14] 5 U.S.C. § 8123(a); *see also Raymond A. Fondots*, 53 ECAB 637 (2002); *Rita Lusignan (Henry Lusignan)*, 45 ECAB 207 (1993).

[15] The A.M.A., *Guides*, Chapter 18 should not be used to rate pain-related impairments for any condition that can be adequately rated on the body impairment systems in Chapter 17. *See Linda Beale*, 57 ECAB 429 (2006).

L5 and S1 nerve roots, for which a maximum of 5 percent impairment is allowed. Dr. Berman classified the sensory loss as Grade 4 or 2.5 percent deficit, resulting in 1.25 percent loss due to each nerve root rounded to 3 percent impairment.[16] He disagreed with Dr. Diamond's calculation of left lower extremity impairment due to motor strength deficit.

The Board finds that this case is not in posture for a decision. There is a conflict in the medical evidence between Dr. Diamond and Dr. Berman as to appellant's left lower extremity impairment. Accordingly, the Office should refer appellant to an appropriate impartial medical specialist for a thorough physical examination and evaluation of his left lower extremity impairment. The physician should be asked to address the extent of sensory and/or motor loss of the left lower extremity. After such further development as it deems necessary, the Office should issue an appropriate decision.

CONCLUSION

The Board finds that this case is not in posture for a decision.

ORDER

IT IS HEREBY ORDERED THAT the decisions of the Office of Workers' Compensation Programs dated July 30 and January 2, 2008 are set aside and the case is remanded for further action consistent with this decision of the Board.

Issued: July 9, 2009
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board

[16] Dr. Berman did not provide any rating for loss of strength.